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THE MADRAS CLINICAL JOURNAL

JOURNAL OF THE MADRAS STATE BRANCH INDIAN MEDICAL ASSOCIATION
(With which is incorporated the "Miscellany")

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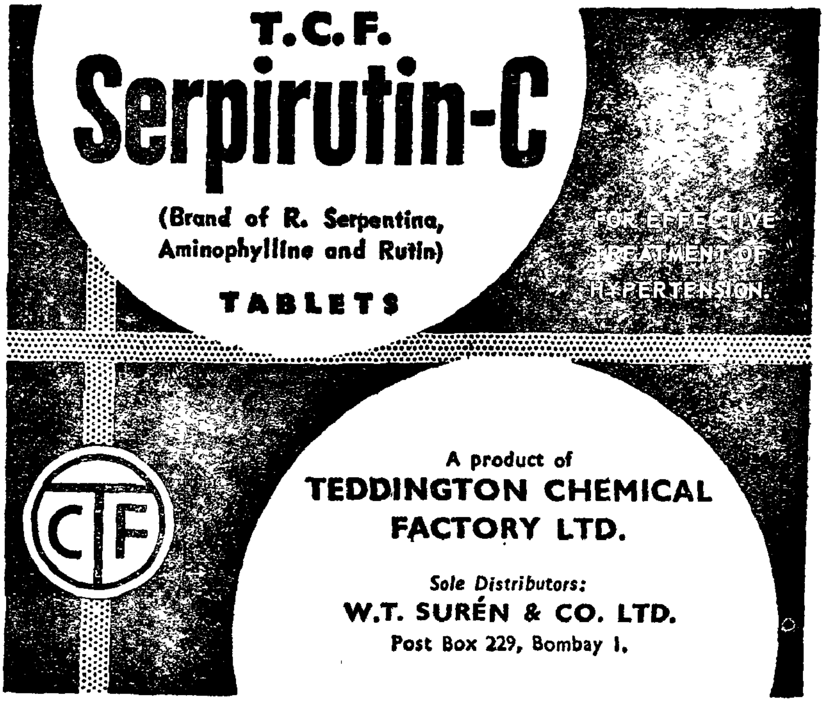

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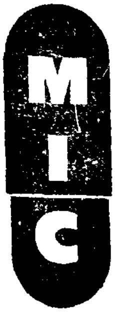

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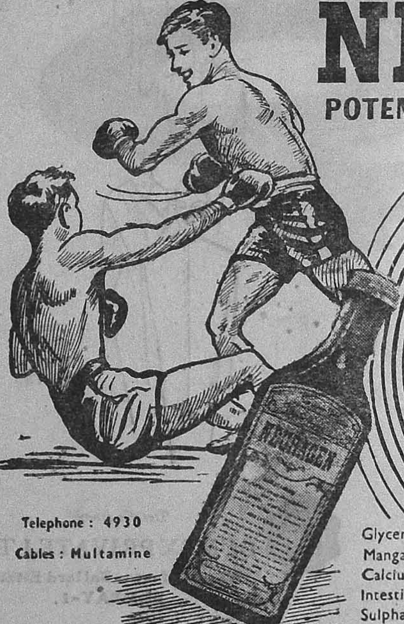

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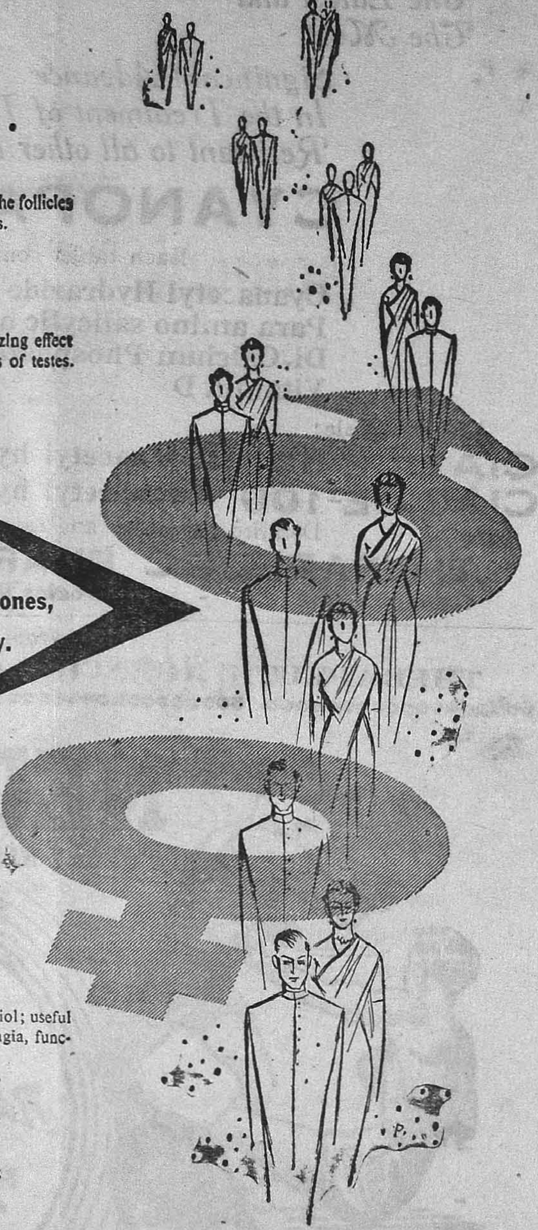

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WHAT CAN BE DONE TO AMELIORATE THE HANDICAPS OF THE DEAF ?

By:

Dr. H. ERIKSSON, M. B. Ch. B.

Swedish Mission Hospital, Tirupputur, Ramnad Dt.

The words "deaf" and "deafness" are not very definite words. They may mean anything, from slight hearing defects to stone deafness.

The American schools for the deaf have agreed upon a certain nomenclature.

I. **"The Deaf"** Persons in whom the hearing is non functional for the ordinary purposes of life.

They are divided into:

a) Congenitally deaf
b) adventitiously deaf

II. **"The Hard of Hearing"** Persons in whom the hearing, though deficient, is functional with or without a hearing aid. If a person is deaf in this sense of the word, there will always be some damage to the inner ear (the labyrinth), the auditory nerve or the hearing centre in the brain. Such a damage can be congenital or acquired.

In the congenital group we may have an aplasia of the labyrinth or the result of an intrauterine labyrinthitis, or a degeneration of the acoustic nerve. Such a damage is often due to a rubella infection in the mother during the pregnancy. In a big series of deaf small children this was found true in 18%. A birth injury to the head may cause a very severe deafness at times.

Among the causative factors of acquired deafness we find:

Meningitis cerebrospin epidemic.
Scarlatina
Typhoid
Measles

In all these diseases there may be a suppurative labyrinthitis. In measles it has happened that the whole concha has become necrotic.

Diphtheria, Mumps, Whooping cough, Lues and Pneumonia are also causative diseases. In severe head injuries there may be an indirect injury to the labyrinth, for ex. fracture of the base of the skull. We must remembor *never* to clean a bleeding ear after a head injury by

syringing. It should be left in peace with a sterile dressing.

A neuritis of the acoustic nerve is sometimes found in severe lung tuberculosis, also in advanced carcinoma, in syphilis, in sepsis, in mumps. Sometimes alcohol, tobacco, lead and carbon monoxide poisoning do harm to the auditory nerve.

In small childern hearing defects may be caused by adenoids and hypertrophic tonsils. Such hypertrophic lymphatic tissue may sometimes block the Eustachian tube and even grow into it.

A very specific and severe damage to hearing is sometimes caused by a toxic neuritis in quinine medication. Salicylates may have a similar action.

An atrophy of the acoustic nerve and the organ of Corti can be the result of exposure to sharp strong noises. This fact has become an industrial problem, as a great many workers of noisy factories get their hearing severely damaged. That risk is also found in aviation. How to protect against such noises or to remove them is uppermost in the minds of scientists working with the problem of adventitious deafness.

The symptoms in loss of hearing are evident to all. And still I am sure that we, who have our proper hearing, have very great difficulty in imagining what it is to be deaf. Such a person will to a great extent be cut off from the normal contact with people.

That will often make him shy, at times also suspicious. And such ideas will also add to his suffering. Some people seem to get quickly used to the loss of hearing proper than to the noises in the ear or the head, which so often accompany deafness, even if it is not so bad. Patients describe these noises as a big rushing waterfall constantly in the ear. And they are really a great strain upon a patient. The aetiology of these noises is not a simple one. Some people complain of an awareness of noises at night from the pulse of the carotids and the rush of the bloodstream through the jugular veins. We can assure the patients, that this is no serious symptom and no sign of danger approaching. It is a sad fact that we have very little, if any possibility of doing any thing about all these troublesome noises, that are such a tiring and exhausting problem to the deaf. When the hearing defect goes beyond a certain limit many persons are unable to continue their work. And here we come across the economic consequences involved in the problem of deafness. And this certainly is a very big and important aspect of the disease.

A deaf patient cannot help himself. And he will get proper help only from expert hands. Such hands need not be exclusively doctors. But the nature of the damage to the hearing sense must be examined, and its severity estimated. That can only be done by a careful examination of the hearing capacity. It will then be found that many have a hearing residue, though that never was evident uutil these proper hearing tests have been completed.

The handicap of the patient will have to be judged from the mental, social and economic point of view. Only if a patient can get an all round help will he be really helped.

Such help cannot be given neither by a private practitioner, nor by ordinary hospitals. They have not

the equipment and the personnel for such work.

Centres should be erected, in good hospitals. and there must be specially trained personnel.

Patients with hearing defects arriving at such centres should first be diagnosed properly about the nature of their deafness. Contributing factors of ill health should also be detected, and treatment instituted. The possible hearing residue should be developed to the utmost. The patients should be taught lip reading and practise it. Those who would benefit from using a hearing aid should be equipped with such one and trained in using it. There are several types of hearing aid in the market. Only experts could definitely say which one would be preferred in a certain case.

In fact, it does not appear to be so important what kind of hearing aid is chosen, the paramount importance is to get used-to it. They will have to use it in different situations. During this training they should start in silent surrounding to get used to the voices of people speaking; later on train listening with noise at the background and finally with plenty of ordinary traffic noise, several people talking at the same time. When they can discern the voices in such noisy atmosphere they have acquired a good control of the apparatus.

In America they have training centres, where people stay 5 weeks for such rehabilitation scheme. That seems a long time. There are also shorter courses. But it happens that 60% of those who have had only a few days course come back and complain that they are not satisfied with the apparatus and are willing to stay for the longer course. There is a tremendous change taking place in the patients coming in and going out of such centres. They come having lost all hopes for the future, downhearted and they leave with a renewed, calm confidence, a new joy and gratitude, appreciating the fact that they will be able to resume their work again.

The teachers of such training centres are college educated persons with special training in acoustic science, physiology and psychology. Patients, who cannot continue in their old work, should get facilities to be trained for some other work where the loss of hearing would not be an absolute obstacle. It is to be hoped that industrial and other concerns will be willing to take persons with hearing defects or other handicaps among their workers. It has been stated that such persons are more ambitious and show more careful handling of all details of work entrusted to them than do ordinary "normal" people. That can make good for their possibly slower speed in the work. This testimony you find in Europe, America, Australia, where there are business concerns which have made it a policy to admit handicapped personel. They have actually found it to pay also from the economic point of view. It is of course also of general interest to utilize all the working capacity of these handicapped persons. Thus the rehabilitation of such people is a common interest - a state concern.

Children, who are deaf at birth, will not learn to speak. They will be deaf and dumb. The most important time for the development of speech is the age form 1-5. Many children have a good command of the language already at 3. They learn to speak by imitating what they hear. But small children easily loose the ability of talking if they get deaf. Only if the deafness comes after the age of 7 can we expect the child to remember enough of the

language to be able to continue speaking it fairly well. The impressions upon the brain of the word-pictures do not appear to be strong enough before that time.

Sometimes children who are deaf may wrongly be considered mentally non developed or backward. Proper examination may reveal good intelligence. There will be great disappointment and sorrow in a family when a child is born with the very great handicap of deafness. And yet this is a situation where you can have good hope, as there is much more that can be done to these than people ever think of.

In many of these children there will be a small remainder of hearing capacity. This can, with proper training be utilised very much; but only if the child comes under training EARLY. You cannot start this training too early - from infancy, from the time of 1 year of age should these children be taught and taught and taught to speak. Calmness and perseverance are very much needed to those teachers who undertake training of deaf small children. Even quite deaf children can be taught to speak and to speak well, if only the training, as said before, starts early enough. If you start at 5–7 you will not at all get the same good results.

Who can undertake this training? Some mothers in different parts of the world are those who have worked it out for their own deaf children. Mothers who will not just leave it at that, that their child should be deaf and dumb. But of course those who have worked that out must have been very intelligent and energetic persons. Otherwise they would never have had the joy of such a success in their efforts, a wonderful result indeed of their never ceasing work with their little ones. In America and also in my country Sweden you can now get booklets with instructions to parents of deaf children. How the training should start and proceed can be learnt from these small handbooks. But even with ever so many good instructions there will be many parents who cannot undertake that work. It takes very much time; that is one thing, and of course an important thing. In such cases it is very necessary that already at an age of 3 the small children should be sent to a school for deaf children, preferably a boarding school. It seems very early, but only then can they really learn to speak properly. If it is day school, it is good if mother or father can occasionally visit the school so as to be able to train the child also at home, having followed the instruction given at school. When the training is started as early as possible, the children can get such a good command of the language and become so clever in lipreading, that 70% of them can attend ordinary schools, high schools and also take up college studies in suitable cases. And then there will be many vocations open to them.

Among the children of ordinary schools, there are quite often some, who are hard of hearing. Sometimes they may be considered not mentally developed, as they naturally cannot grasp the teaching, if their hearing is poor. Some of them may later prove to have quite a good intelligence.

In Sweden all the children of the town schools are being tested regarding their hearing ability. Those who are hard of hearing will be transferred to special classes for such children. They will get a proper medical examination. Adenoids, tonsils or other complicating factors will be dealt with. In these special

classes the children will also learn lipreading and those who can be benefitted by using a hearing aid will be provided with such one, and be trained in using it. Who will pay these rather costly apparatuses? Sometimes the Red Cross can do such a thing or other local bodies. But there is the aim to make the Government provide them free of cost. A Parlimentary decision this year has met that request, but not yet to 100%.

The work for rehabilitation of the deaf and the hard of hearing may of course be handled differently in different countries. In America it is included in the Public Health Programme.

In Sweden we have an "Association for promoting hearing". This association has branches all over the country and tries to get in touch with as many people as possible, who have defective hearing: They arrange courses for: Small children; small children and mothers; school children; adults; and teachers. In the courses special attention is given to correction of faulty speech, faulty pronunciation, and to using the voice. Some deaf persons have a tendency to talk so silently that it is very difficult to catch what they say. Their own hearing cannot control the force of the voice, and so it is not easy for them to learn this control. The practice in labiology/(lipreading) must also have good training so that all acquire a good knowledge of it. The association has a Control Office, which is also a centre of supply of hearing aids. People getting such, also get training in using them through the same association. This office tries to get hold of old hearing apparatuses to repair them, if that is possible, or to destroy them if they are unserviceable, so that none should be able to get such for sale.

The Sweedish Government has appointed a committee to undertake the activities for rehabilitation of deaf and the hard of hearing. They should primarily arrange training facilities for teachers for deaf children; for social workers, whose duty would be to contact and counsel deaf persons, or parents of deaf children. Nurses are also trained to test the hearing. Thus it is possible to do this more regularly also in the countryside, where district Nurses who have got the training can undertake this testing and follow up of the school children.

There is special stress laid upon influencing public opinion to accept the deaf socially thus and save them as far as possible from the feeling of being shut off from normal contacts with people, and to be willing to provide opportunities of work to those handicapped through deafness. People are urged to speak clearly; if all did so, the hearing difficulties to the hard of hearing would be reduced by 50%.

This Government scheme will be divided into 3 departments:

1. A Technical-acoustic Department in charge of a doctor.

2. A Pedagogic Training Department in charge of a specially trained teacher.

3. A Social Department in charge of a social curator.

This Government activity gives much room for private initiative. And the Association for promoting hearing will still have very much to do in this wide field. They have more possibilities to get deaf persons to-

gether and give them a platform where they can discuss common problems and make their voice heard on such questions, that concerns the work of rehabilitation.

What is done in India for the deaf?

There are a number of schools for such children mostly private enterprizes. But they are of course not sufficient for the great need. This was also stressed at a meeting on 23rd of Sept. this year in Mussooree. I quote from a paper Madras Mail. "The 6-day Seminar on The Education of deaf today urged the Government to open more schools for the education of deaf in all parts of the country".

The Seminar, which passed a number of resolutions, urged among other things, that special technical training should be imparted to the deaf, in trades like masonry, carpentry, workshops and welding, and that such training schools be established on zonal basis.

The Seminar was of the opinion that there were many difficulties for the deaf children to receive secondary and higher education. It recommended early establishment of some special secondary schools and colleges for the deaf. It also requested the universities to provide facilities for the deaf to appear as private candidates. In another resolution. the Seminar urged the State Governments and other agencies to make provision for better employment opportunities to the deaf.

The measures suggested in this connection were the setting up of special employment advisory committee in major states, the estabilishment of a net work of employment organisations for the deaf, the formation of co-operative societies by the deaf, and preference to these societies by the Government in giving contracts.

The Seminar also urged the Government to bring forward a legislation to compel the insurance companies to accept insurance policies on the lives of deaf, which are refused at present."

We may ask, is not the outlook for deaf people is very much brighter today than a few years ago? We then think most perhaps of the great surgical achievements in this field, that have now been used for some years. The fenestration operation in otosclerosis, which provides hope for many, and the plastic operations to substitute the destroyed tympanitic membrane, which restores the hearing to quite a number; all these are certainly very great achievements of modern time. And so also the hearing aids. But all these measures are for those who have nerve conduction and hearing centre intact. We must say that the achievements for those children with congenital or early acquired total deafness, with schools and even colleges open to them is just as great a boon. If we say that the former types are the result of hard, intelligent scientific work, we can say, that the latter achievements are the victorious result, of the mighty persevering love of mothers.

* Lecture delivered at the Tiruchy Branch of I. M. A. on 29—10—55.

THE USE AND LIMITATIONS OF CORTISONE AND A. C. T. H.

By:

Dr. S. SANKARARAMAN M.B.B.S., CUDDALORE.

It is a well known fact that animals without Adrenal Glands resist the stresses of truama infection and toxaemia less well than those with healthy tissue. Stress stimulates the adrenal cortex to throw out adrenal cortical hormone into the blood stream and thus screws up one's courage. This increased concentration of the hormone in the blood helps the cells of the body to resist adverse trends in the internal environment. How this is effected and what is the path from the stress area is still not known.

Ever since the publicity given to the impressive and prompt response of Rheumatoid Arthritis to Cortisone and A. C. T. H. therapy, these hormonal preparations have been used in many an ailment with varying success and it is time enough to assess their usefulness and their limitations in these conditions.

Cortisone is supplied either as tablets of acetate for oral use or as a suspension of finely divided crystals of cortisone acetate, in a saline medium for intramuscular injections. In the oral route the absorption is quick and the therapeutic effect is rapid, but the amount in the blood concentration falls in a few hours to the original. In the intra-muscular route, the absorption is slow, enabling more and more to collect at the site of the injection thus producing a depot of cortisone which is slowly absorbed. Blood level rises slowly and lasts for a week even after the injections have been stopped. The dosage of cortisone varies according to circumstances from 25 mgm to 200 mgm per day.

A. C. T. H. (Adreno-cortico-trophic hormone) is a highly purified protein fraction of the anterior lobe of the pituitary. It stimulates the adrenal cortex thus increasing the production of its own hormones. Since it is destroyed by the digestive juices, it must be administered by the parenteral route only. When given intra-muscularly, a greater part is destroyed locally or in the blood stream, and only a small part is available for adreno-cortical stimulation for a short time only. Hence injections have to be given four times a day in divided doses. A. C. T. H. incorporated in a gelatin vehicle is available in the market, each c. c. containing purified corticotropin equivalent in clinical activity to 40 U. S. P. units. 50 units of A.C.T.H. intramuscularly twice on the first day and once daily for two more days and then trailing off to 10 units is recommended. A. C. T. H. can also be administered as a slow intravenous drip dissolved in saline for six to eight hours a day.

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* Lecture delivered at the 10th Madras State Medical Conference, Salem on 26-11-55.

A. C. T. H. and Cortisone have proved their value in the following diseases ;—

(A) COLLAGEN DISEASES ...	1. Rheumatoid Arthritis 2. Dermatomyositis 3. Lupus Erythematosus 4. Acute Rheumatic fever 5. Peri-arteritis Nodosa 6. Thrombo angitis obliterans
(B) METABOLIC DISEASES ...	1. Gout 2. Hypoglycemia 3. Nephrotic syndrome & 4. Ulcerative colitis
(C) HYPERSENSITIVITIES ...	1. Dermatitis both contact and atopic 2. Drug sensitiveness 3. Hay fever & Bronchial Asthma 4. Urticaria
(D) SKIN DISEASES ...	1. Psoriasis 2. Exfoliative dermatitis 3. Phemphigus
(E) OPHTHALMIC CONDITIONS	1. Limited ocular lesions such as acute iritis, allergic conjunctivitis & keratitis 2. In chronic eye disorders where the exudative phases of inflammation threaten the functional integrity of the eye 3. As a prophylactic against invasion by susceptible exogenous organisms For these ocular conditions topical applications of a suspension or ointment is recommended.

What is this Collagen Disease? Although the spectrum of diseases covered by the term "Collagen diseases" is not easy to demarcate with any exactitude and is still debated by those, who introduced this nosological concept, yet there are certain basis on which these diseases are grouped. Klemperer (1950) used the term Collagen in the sense that is meant all the components of connective tissue. The following are characterestic of Collegen diseases :—

(1) There is primarily an alteration in the physicochemical function of

the connective tissue in all Collagen disorders.

(2) There is degeneration of the connective tissue fibrils and there is fiibrinoid degeneration.

(3) Hypersensitivity is a prime aetiological factor.

(4) The therapeutic effects of cortisone in these diseases are striking.

Connective tissue is no longer regarded as a mere scafolding for parenchymatous tissue and organs. The questions whether the anatomical lesions in Rheumatic fever and disseminated lupus erythemetosus were primarily cellular or vascular has been engaging the attention of research workers. Klinge and his coworkers noted similarity between the lesions in Rheumatic fever and those produced experimentally in rabbits rendered hypersensitive to foreign protein and put forward the theory that the pathogenesis was allergic and resulted in degeneration of connective tissue.

Connective tissue is composed of cells and extra cellular structure. It is the secretary activity of the connective tissue cells which produces the extra cellular structure. The latter comprises of Collagen, reticulin, elastin and ground substance. The ground substance is mucoid and is composed of hyaluronic acid and chondroitin sulphuric acid.

Hyaluronic acid is a mucopolysaccharide and is present as a predominent factor where lubrication is required. Chondroitin sulphuric acid is abundent where toughness of the connective tissue is required. It is Hyaluronic acid which first undergoes alteration in diseases of the connective tissue and thus the Collagenpolysaccharide complex is weaken and the collagen fibrils degenerate and a homogenous, eosonophilic, relatively a-cellular refractile substance is left behind and this change is known as fibrinoid degenation.

The factors involved in the production of fibrinoid degeneration has been ascribed to (1) an excess of mineral carticoids over gluco-carticoids. (2) an excessive production of harmones from the anterior pitrutry or adrenal cortex and herein comes the usefulness of cortisone and A. C. T. H. in these diseases.

1. **Uses** :—The conditions in which cortisone is primarily indicated is "Addisons disease and Hypopituitrism." Cortisone 25 mg. daily orally is adequate for maintenance therapy. The symptoms are alleviated and benefit bestowed by regular cortisone enables the patients to carry out jobs satisfactorily.

2. **Rheumatoid Arthritis** :— All cases of Rheumatic athritis benifit considerably, the exceptions being advanced cases wite severe contractures and burnt out inflammation. Pain, joint tenderness, and stiffness diminish early, periarthrtic swelling and inflammation diminish in more variable degree and more slowly. The appetite and optimism of the patient is much improved. The fever, if any, is reduced to normal. The E. S. R. falls and may return completely to normal. The persistant anaemia is improved. The mobility and agility is increased.

Initially A.C.T.H. must be given 80 to 100 mg. doses divided in 6th hourly doses or one single injection of 40 mg. of gel. When remission is obtained dosage is gradually lowered to the lowest figure that will maintain a control of the disease i. e. 10 to 30 mg. daily.

If Cortisone is administered the initial dose should be 200 mg lowered after a few days to 100 mg. A daily maintenance dose of 75 mg is often required.

3. **Rheumatic Fever**:– The temperature falls to normal in a day or two, the tender and swollen joints return to normal and general condition of the patient is improved. The classical manifestations of Rheumatic process are suppressed.

The action on Heart failure symptoms are very effective. The good effect on the myocordium outweighs the tendency to increase sodium retention. Heart size may diminish and P. R. internal on the E. C. G. shortened. The action is purely suppressive and relapses will occur on stopping the therapy. Hence traditional treatment as salt restriction and mercurials must also be given. It is also claimed by some that valvular damage is prevented. The starting dose is 200 mg daily of cortisone or 100 mg of A. C. T. H. After a week the dose is reduced to 100 mg daily of Cortisone or 25 to 40 mg of A. C. T. H. continued for four to six weeks generally i. e. until there is no sign of recurrence.

4. **Disseminated Lupus Erythematosus:** The characterestic L. E. cells should be found in the blood and bone marrow. Fever is gone as also the first symptoms and skin manifestations, though more slowly. The E. S. R. falls, but the anaemia persists. L. E. cells do not disappear with A. C. T. H. or Cortisone therapy and hence treatment must be continued for long periods. In late cases the rapid downhill course is not prevented.

5. **Periarteritis nodosa**:– In early cases remission will recur but in later cases with severe cardiac or renal damage no benefit can be expected.

6. **Dermato myosits**:– The pain and oedema is reduced and symptomatic improvement is achieved.

7. **Asthma and allergic status:** In status Asthmaticus failing to respond to adrenaline and other adrenergic drugs and where a fatal termination is inevitable, prompt use of A.C.T.H. has a dramatic effect of saving life. Intravenous drip 25 to 40 mg of A. C. T. H. dissolved in 500 c c of saline and administered slowly over several hours, produce a very good response. Alternatively 25 mg sixth hourly I. M injections are quite good.

In severe bronchial asthma, a two weeks course of 40 to 60 mg daily of Ac-C Hgel can be usefully tried to give relief for several weeks.

Acute attacks of allergic asthma is controlled by A. C. T. H. or oral cortisone. In drug sensitiveness and other allergic skin manifestations, prompt response takes place.

I can vouchsafe the usefulness of this drug. In one of my cases of status asthmatic where I was at my wits end when adrenalin euphedrine and all common drugs failed, A.C.T.H. produced a dramatic result.

8. **Psoriasis**:— I had given this drug in one refractile case. The patient had relief in two days and had a relapse after six months, when a second course of treatment was given and the patient is free for the last 1½ years.

200 mg. of Cortisone orally daily trailing off to 40 mg. in a week and continuing 25 mg for a further week was all the patient can afford. It is said that failure to get improvement is due to inadequate dosage.

Eye diseases :— The local application of cortisone to the eye is so effective that there is no necessity to use A. C. T. H. or cortisone parenterally. Cortisone may be applied directly as drops, the standard preparation being diluted 1:4. It is instilled every hour until inflammation subsides, or an ointment of 15 mg per gramme in lanoline may be applied every three hours. The results are often dramatic in iridocyclitis, conjunctivitis and acute corneal ulceration. Cortisone prevents vascularisation and infiltration thus minimising scarring.

In sympathetic opthalmia, it is sight saving. Cortisone should not be used for ocular conditions suspected of having tuberculosis for it lights up a relatively quiescent focus.

Blood disorders :— Acquired haemolytic anaemias whether idopathic or symptomatic are greatly benefited by cortisone therapy as well as A. C. T. H. administration. Thrombo cytopenic purpura, whether toxic or essential is also improved by prompt treatment. In acute letkemia in children a beneficial response is obtained.

Renal disease :— The one condition in which cortisone is useful in nephrotic children without significant nitrogen retention, where a withdrawal diuriesis occurs and renal oedema is reduced completely. The child must be on low salt diet and a high potassium diet. Full dose must be given ¾ mg per kg of body weight for about 8 days and then dosage trailed off till the 12th day. Particular attention must be paid to the cardiovascular system during the course of the treatment. I have given cortisone as a last. desparate remedy in nephrotic children where all the usual remedies failed and I had very gratifying results in the reduction of the Oedema. But cortisone has no action on the underlying course of disease and cannot be expected to cure the condition.

Very recently filarial elephantiasis has been treated with cortisone by Mr. Markel of the university of California, school of medicines, with marked response. 100 mg of cortisone daily for a period of 30 days or more were given and the induration was reduced in some and disappeared in others. The improvement; persists for 7 to 10 months and when relapse occured retreatment with smaller doses of cortisone was found to be beneficial. According to him the benefit appears to be due to a reduction in the inflammatory blockage of the lymphatics. The total number treated is only eight and hence it is too early to give an opinion on the efficacy of cortisone in elephantiasis.

The results of Cortisone therapy are purely empirical and how it acts is till not clearly known It has been suggested that A. C. T. H. or Cortisone raises the concentration of adrenal cortical hormone in the circulatory blood and acts by being converted within the body into compound F (17 hydroxy corticosterone and increasing the resistance of the cells of the body to adverse trends in the internal, environment. It has no specific action on specific diseases but acts by protecting the tissues of the body against diseases in general.

A. C. T. H. and Cortisone act as an asbestos clothing to a fireman in the middle of the fire protecting him from the fire without putting it out.

The main limitations to its use is that one cannot stop the treatment suddenly, since the hypertrophied and over-acting adrenal cortex

suddenly deprived of its stimulus becomes inactive for a few days and adverse effects follow. The dose of A. C. T. H and Cortisone must be tailed off gradually to a low level before stopping treatment altogether.

In the adrenals are absent or diseased, A.C.T.H. having no target to attack proves of no value. Only Cortisone can be tried usefully as a substitution therapy only

In Rheumatoid Arthritis, their good effects last only while taking cortisone or having injections of A.C.T.H. The withdrawal of these drugs undo all the good they have done and, what is worse, the patient gets disappointed when he becomes alive to the fact that the drugs act only like Insulin to a diabetic, doing good only when having them.

In acute rheumatic fever, Cortisone act better than salicylates but it has no action in preventing valvular damage. Two of my cases treated with Cortisone returned after a year with mitral affections.

The action of this drug in Lupus Erythematosus is only effective when taken up early in the disease and here too relapses are common. The suppression of fever, joint symptoms and skin manifestations are achieved only when renal damage is not severe.

In peri - arthritis nodosa, these drugs show slight remission only in early cases and are not only useless but definitely harmful when there is associated or renal damage.

Cortisone or A. C. T. H. causes sodium retention in nephrotic children with poor renal function. In three cases of mine where this remedy was tried, the oedematous condition was cured but ultimately the patients died of renal failure.

The next contra-indication is the masking of the grave symptoms. The temperature associated with infection is reduced to normal, the malaise of toxemia is prevented; the sedimentation rate is reduced to normal and there is a sense of well-being in the patient, although the underlying cause of trouble is doing its mischief. Cases of extensive peritonitis have had their symptoms masked with fatal consequences. Though Therapy with Cortisone and A. C. T. H. is continued, other traditional remedies must be relied upon without being lulled into a sense of false security.

The third contra - indication is undiagnosed diseases. These drugs are not to be lighty given since they are no panacea for all disorders. More harm than good will result when these are given in undiagnosed or ambiguously diagnosed cases.

The fourth contra-indication is a tubercular patient. A. C. T. H. or Cortisone lights up the latent tuberculosis and hence they must not be administered to a patient with active or latent tuberculosis or applied to the eye suspected of tubercular condition.

The fifth contra - indication is its overdosage effects. (a) **Sodium retention** leads to water retention and oedema. In congestive heart failure, the oedema is aggravated, Jugular venous pressure rises and the condition becomes worse. In nephritis, there is sodium retention but withdrawal diuresis occurs in a majority of cases sodium intake must be restricted during the course of treatment.

(b) **Potassium loss** leads to muscular weakness and E. C. G. changes in the heart action.

(c) **Calcium loss** though not of much significance, is bound to cause disorders of calcium metabolism e. g. steatorrhoea of non-trophical sprue.

(d) **Disorders of carbohydrate metabolism**:- The blood sugar rises and in the established diabetic, insulin dosage has to be increased considerably. Even non-diabetics may suffer from glycosuira.

(e) **Increased adrenal cortical stimulation** The production of adrenal androgens results in masculinisation in females. Acne, amenorrhoea and hirsutism develop.

(f) In Cushings syndrome, hyperactivity worsens the disease.

(g) **Psychological changes** Euphonia is common. Depression with insomnia occurs in some. Frank psychopathic tendencies develop and if the patient had a latent mental abnormality, it is made manifest and worsened.

The efficacy of treatment with A. C. T. H. and Cortisone can very well be judged by the clinical improvement in the initial stages but unfortunately symptoms often returned when treatment was stopped and some even have a relapse while in the maintenance dose. Although most cases respond favourably to the initial course of treatment, the second course is less effective than the first and most cases respond hardly at all to subsequent relapses.

These drugs have to be used with caution in selected cases bearing these limitations in mind.

These drugs should not be used in the management of infections of average severity which will respond well to antibiotics alone and when used in infections of more than usual severity they decrease the morbidity and mortality rates but remember that the corrective influence on some of the manifestations of diseases must always be obtained under an antibiotic umbrella. It must also be borne in mind that these must be administerd no longer than is absolutely necessary and that the antibotics must be continued for atleast three days after the cessation of cortisone and A. C. T. H.

References Medical Digest — Vol 23 No. 8 P. 594—597.

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RESEARCH AND MEDICAL PRACTICE

By :

Dr. N. G. PANDALAI, M.D., D.T.M., F.R.C.P.

Madura Medical College, Madurai.

As an introduction to my theme, I like to say that in my to-day's talk you will find nothing new. I shall be only going over what many others in the past have said in better form. The subject is one of which I may be talking with special feeling, because that has been the subject of my thought for several years in the past, especially about India's part, rather no part, in the clinical research and the building up of clinical medicine. You may then consider this talk merely as an exhortation, entitiled to make in virtue of age and some little experience. To most of you what I have to say may appear trite and common place or theoretical and ideal. Sometimes I may appear talking cheap or like a teacher. Having been one nearly all my official life, unwittingly though, I may lapse into the pedagoge. Many of you, I trust, must have reached, or be nearing, my age of waning energy and zest for active study and contemplation. Also, few among you will need the leaven to raise you out of the common: Bear with me for all these: that is my earnest request to you all this evening.

When we think or talk of research, the first impression weighed up in our mind is that of lavishly equipped laboratories, microscopes, testtubes, experimental animals and other costly appurtenances. That is but one type of research, call it academic research, if you like, and, nodoubt, essential in all basic sciences and even in clinical medicine. Nor should be we be lead away by the idea that it is superior to other forms of research. That is no so; in the realm of medicine clinical research occupies by no means as insignificant place; its cultivation is important, may imperative, in order to enrich medical knowledge and make it serve the best interest of the suffering lot. If that were not so, luminaries of the medial firmament, like Bright, Laennec and Osler, will have to be assigned backplaces as mere followers of the healing art and no more. This was by no means the case, and the high level of excellence the clinical medicine of today has attained was due not a little to the selfless and sustained labours of eminent clinical teachers, inspired by a spirit of disinterested curiosity to learn the physical manifestations of disease in man, in all its fulness. Experimental medicine, whenever resorted to, was but as a hand maid to clinical medicine. However, it will not be true to say that the pragmatic but selfless desire to alleviate or eradicate the suffering of their ailing fellow creatures, restoring health and happiness, was not likewise a predominant component of their motive force. Be that as it may, the above attitude towards clinical research has all but changed even in this country and change it should. In clinical medicine too we have not reached a finality ofknowledge. Knowledge is expanding. Nature is immensely rich, but only silently inviting. As though not to dispirit and thereby thwart the seeking man, she seems to be hiding her treasures less and less, yielding more and more by degrees to his hard knocks at Her gate.

What can our practising colleagues do in this matter? Quite a large bit indeed. It is not a mere can; it is a must; it is a solemn responsibility, onerous indeed and may be profitless too in the material sense but extremely

satisfying and joyous in the end. Adding to the sum total of knowledge, expanding its frontiers even by a tiny bit, is a noble aim, probably an ideal one. For does it not also, often indirectly though, help in promoting the happiness of man? The imposing edifice of clinical medicine we have today was not built in a day; it is the accumulated effect of the untiring and selfless labourers of men and women through the ages. Glancing back, however, in this, we in our country can boast of no part. We were not partners in the building up; we only enjoy the fruits of their labours. We are living, parasitising so to day, upon the accumulated wealth of western thought and action. Even today we live upon imported knowledge equipment and books. All thanks to the west. I do not mean to say that in this pursuit of knowledge any path we may have to travel is ignoble but I mean it is infinitely more ennobling that we too make efforts to further add to that knowledge for humanity's sake. Therefore it is that in this no question is involved whether we can or cannot do research, but only an emphatic affirmative that we must do it. It is a serious duty of ours, not to be imposed from without, but spontaneously coming from within; self-respect demands it. Let this then be the practising doctor's contribution in the country's efforts for harnessing the post independence outburst of national energy. Let me not be understood as unmindful of the work currently done.

I am well aware that research talent is not a quality native to all. With proper stimulus it can be awakened in those in whom it lies dormant. Some of us may also be thinking that we haven't the research proclivity; their mind is caged or hypnotised. But what is more to the point is that many of these potentially capable doctors may not be making any serious effort. My address today is mainly to them. We have been so long dependent that we are also prone to think that all original work can come only from abroad, from superior type of learned man. That is the thought of a pathological mind, the progeny of faulty training, entirely wrong and fundamentally to be changed.

The question arises whether the busy practitioner has the training or the facilities necessary for research or what is infinitely more important the necessary time for any original study and restful meditation. I am not one of those who think that only the highly qualified, academically trained doctor is good enough for or capable of exploring new grounds. The basic training we have had is sound enough and informing enough to build upon a research superstructure. Any practitioner who has a spark of adventure in him the necessary research potential; only he must awaken that spirit and guide it through proper channel. To follow the routine of practice is easy enough, but to make that routine along research lines needs besides curiosity a true and ativated interest backed by conscious effort. He who has the firm will can certainly develop by steady practice the necessary skill; with determined application the requisite training can be gained. With expeirence, grows wisdom and he develops the quality of critical evaluation. For research the practising doctor does not require elaborate laboratory or other equipment . And in this, unlike his academic colleagues, he is at a great advantage. He can combine his professional work with clinical research. Indeed, without the former the latter is obviously impossible. The man of clinical research is not hedged in by any barriers of experimental edifice; no compulsive limitations of equipment may stand in his way. Per contra, he has the advantage that every sick man's house in

his laboratory, every patient an experimental animal. Where he can commanded any time is another question. If the irrespressible urge for research is there he will find the necessary time, will find ways of deviating some of it in the pursuit of study and research, though no doubt, that will make some sizable encroachment on his bread earning activity. But that of spontaneous self denial is the quality of an aspiring mind that will consider no sacrifice too great, no work too low or too hard to achieve great things.

I may be pardoned if in this context I make a passing allusion to the problem of the uneven distribution of doctors in this country of acute under production and short supply. No doubt, this question is now engaging the serious thought of those who are concerned with the general and total improvement of our national health. Here I shall confine myself to where the problem impinges upon clinical research.

The rural and urban areas are still unexplored in respect of health and health conditions. They form a veritable mine for research of all sorts. Past sins have preserved that rich heritage Malnutirition, almost unchanged for succeeding generations of doctors, undernutrition and even starvation are the order there. Insanitation and all other circumstances making for easy contagion and infection are there too. The general and total health is poor. But yet the teming mass still live on and go on with their useful toil and homely joys, not only maintaining but also adding to the national wealth. We have learned that such adverse factors are highly prejudicial and injurious to well-being. Here then appears to be a machanism of disease some what different. Again, there is there a diversity of diseases with their natural history evolving on that peculiar background, readily observable and lending for fruitful investigation with patient perseverance Here is also a fertile field for unfolding of the factors of action and reaction with reference to man and his environment; what their genesis is and how a large mass of population adjust itself against those natural factors, maintaining the balance in nature, are all vital problems awaiting critical study and elucidation. In all these there is thus an untapped wealth of material silently inviting you to make use of, provided you have any spark of intollectual curiosity. But unfortunately most of our doctors turn a blind eye; they choose to work in cities and large towns, and this tendecy would seem to continue for a long time more, probably until the conditions of living in the backward are has become lots more attractive and remunerative. And until great attention to the general health is bestowed and vast improvements effected in the general well being of the population there with resulting reasonable increase of amenities, the above mentioned condition is difficult to encompass. Thus, it is a vicious circle which must be broken at any cost, if we are seriously bent on improving their lot and therewith the national health and prosperity.

I do not propose in this context to analyse further the reasons responsbile for the disparity of distribution in the different parts of the country; suffice it to point out that it is there and it has to be urgently levelled over. To my mind there appear to be only way of solving this inequality with any prospect of immediate effect. And there is no time to be lost; we are already late. It was my privilege in my official capacity several years ago to submit suggestions regarding certain problems of medical education. From that I may quote a relevant passage. Discussing about compulsory internment I said: " that, as in Russia

all the medical graduates passing out of a college should be required to serve in the rural districts for a period of three years. They join rural medical stations where they work as assistants to experienced doctors, where available. Only in this way we can solve the problem of the over-crowding of doctors in cities and towns at the expense of the rural areas and at the same time give the young graduate a chance to acquire practical experience and bring him in touch with the rural population whose problems he comes to know. They should be paid well. In fact, in Russia doctors in the rural areas receive salaries higher than those of city doctors in the corresponding positions. The more arduous the natnre of the work or the more distant or unattractive the place the higher the salary. It is only after the completion of this very useful apprenticeship that the young doctors would be permitted to choose thair career or proceed for higher studies and specialisation !! Larger production of doctors to meet all the national demands is necessarilly a slow process. Also, our country is poor and the medical course very costly. That too is a serious problem. The poor but deserving entrants should be given free tuition and free books and equipment and free boarding, no matter the number, only quality should count for this award. Although several years have elapsed since making the above suggestion, I have not been able to think out any sounder alternative.

A change of outlook in the practising doctor is what is needed. True, the doctor's chief function is the care of the sick, that work is truly exhausting, saddled with responsibilities and acutely conditioned by competition and financial uncertainties. Parenthetically, I may add that the desire to, live well and with reasonable comforts in instinctive in man; only, money making as such is not an ennobling profession. To underestimate the situation will not solve anything. The doctor is also a member of the society and he has all the obligations and responsibilities as a citizen. He must also find time to read and refresh, lest he should stagnate and deteriorate professionally his use to the community there by going down. If he does, all these he would have done a good job. But there can be something more, something higher for the aspiring mind of man. Is it not nobler to aim at such loftier ends? That undoubtedly involves hard work and denial of other good things of life. Work is the open seasame, the " Master-word ", as Osler puts it, for all success. That is the touchstone of all conquests. The pursuit of research is a superior type of intellectual work and it demands single-pointed attention. To know more, again, is a craving of the cultured mind. To seek limelight by easy means is incompatible with true creative search. It is indeed, a hard path but, what abiding thing as been achieved by easy life? "But they, while their companions slept, were toiling upward in the night." Mention has been made that the practising doctor can combine clinical research with his routine practice. Right from the beginning he must train himself to approach, his work with a spirit of objectivism and a sense of scientific detachment.

Assiduously he should cultivate the habit of order and system. That is an esential pre-requisite for all work, particularly scientific work. Our understanding of the phenomena of health and disease is still in many respects far from complete. True, we have a wealth of knowlege patiently acquired through centuaries of observation and study. But what we know is only a fraction of what yet remains to be known; knowledge is limitless

but fugitive, only with laborious and persistent will can we get a glimpse into its " ample page, rich with the spoils of time." The seeker after truth needs infinite patience. New thing will not come his way every day; he has to watch for them with patience and earnestness. Even in the humdrum of everyday practice opportunities will present themselves to him. He must seize them and make the best use of them. He must make careful observation, collect his facts, classify and correlate them, and all these with an objective detachment never tyring to fit your observation with your expectation. A thorough study of every case and from all aspects is very essential. The habit of keeping full case reports of all patients, so that you may delve into them periodically for comparision is sine qua non of all systematised work. With every success our interest waxes, but no reverse should be allowed to damp our enthusiasm. Indeed, the doctor with an abiding passion for creative work by nature maintain an unflagging enthusiasm. Unusual or unexpected observations however trivial they may seem at the moment, should not be discarded as insignificant or valueles, but recorded and preserved for the future. It may not be practical or often necessary thus to study every case. Therfore, you may take one or two groups e. g., pneumonia or enteric fever. Do not depend on memory, but from the beginning practise the art of keeping careful records of all cases of special study and critical clinical examination in a systematic way. Where possible try to do or get done all test necessary for a correct diagnosis.

It is worth bearing in mind that practically all textbooks you have studied were written by foreign authors, with scarcely any knowledge of the peculiar conditions obtained in other countries but largely on the basis of their own observation and study of patients living in their own conditions and environments.

A typhoid case occuring in an English town, for example, does so on a background of poor or negative specific resistance of the general population and in spite of highly developed sanitary and other protective measures of general nature, where as in this country, and especially in the rural and urban areas, people can reasonably be expected to have developed some level of immunity against that disease for the very reason of the absence of such safe gurading and protective measures. Also, our people are relatively ignorant and very poor. This background for disease evolution is altogether different from the other. For these reasons too, if your clinical observations do not agree with your textbook lore or the teaching of your own teachers, do not turn them down as due to wrong observation. But make repeated observations and strethened by such further confirmation, do not be afraid of presenting your results to others, not for lime-light but for corroboration or correction. Diffidence is not a virtue, while a strict judgement of yourself is very essential. When once you are convinced, be loyal to your own observations and be humbly bold to submit your facts for dispassionate scruitiny. One word of warning; sometimes tinsel may appear as glittering gold and you may be tempted in to rush with it to the print. But forbear, and not until it is tested in the furnace of repeated study should you consider it as true gold and present it as such. For the majority of practising doctors the experimental method and verification is out of the picture. But experimental method is often for confirmation of bedside stuies and observations.

The practising doctor's field in our country is becoming wide. In

the new set up he will also be called upon to perfrom other duties. It will be incumbent upon him not merely to attend to the sick but also to educate the individual in the ways of healthy living — that with the facilities at his disposal, severly limited as they are, it is yet possible by an intelligent utilization of them to provide himself with better sanitary and food conditions indispensible for building up better health and live a more comfortable existence and that it should be a major interest in life not allowing it to drift along passive line with fatalistic faith or indifference. The doctor may likewise be called upon to bestow more attention to the community than to the individual. Service to the group is rightly being given more prominence than service to its component part. In fact, the plan is to orientalise the future medical structure definitely in this direction. Thus, in the changed setting too the inquiring doctor will have ample scope for research; his opportunities for exploring new fields will be actually widening; dearth of material will not be a limiting substance.

The patient painstaking seeker. who carries a scientific and inquiring bias into his work, will thus find plenty of opportunities during his everyday contact with his patients to gather in course of time a good harvest of new facts and figures. Periodically, he may check his material classify them for other's judgement. Calm and dispassionate reflection over his collected data leavens his thoughts and in this process vistas of newer problems will surge up in his mind, crystallising into conceptions very necessary for advancing his work. This reflective thought sharpens his powers and deepens his thirst, spurring him on to greater and greater efforts.

The glow of success is the surest incentive on the path of adventure. He should not falter or shrink at difficuties or disappointments; the path may be strewn full with them. Always his gaze should be forward. If he has the will the way is there "to strive, to seek, to find, and not to yield."

For all these what is the inquiring doctors' ultimate reward? In terms of material prosperity there may not be much; in terms of a name, in being able to leave some foot-prints on the sands of time, there may be something. Finally there is the undeprivable joy, the supreme satisfaction of having lived a dedicated life of service to the suffering mankind. What else can be nobler, more satisfying and joyous?

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* Speech delivered at the annual Day Celebration of the Madura Medical Association.

ELEVENTH MADRAS STATE MEDICAL CONFERENCE-TIRUCHY.

At a meeting of the association held on 21st April 1956 in the premises of the Medical Association Buildings, Tiruchy the following office-bearers were elected for the conference.

Chairman-Reception Committee :	Dr. V. Enok
Vice-Chairman :	Dr. K. G. Menon
General Secretary :	Dr. V. Ananthagiri
Treasurer :	Dr. T. V. Ranganathan
Scientific Session :	Dr. N. C. Subramanyam
	Dr. T. V. Srinivasan
	Dr. T. V. Sundaram
Souvenir :	Dr. R. Kalamegham
	Dr. S. Venkatesan
Food :	Dr. V. Subramanyam
	Dr. A. Dharmarajan
Reception & Accommodation :	Dr. P. A. S. Raghavan
	Dr. G. Joseph Gnanadickam
	Dr. G. Viswanathan
Entertainment & Transports :	Dr. T. S. Balasubramanyam
	Dr. C. M. S. Rajan
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THE LASKER AWARDS

A review of ten years of prizes for scientists shows notable achievements in medical research by recipients of the awards

By Howard A. Rusk, M.D.
From THE NEW YORK TIMES

The merited recognition given a distinguished group of scientists as the 1955 recipients of the Albert Lasker Awards has highlighted the tremendous gains made in medical research in the past decade.

Now among the most coveted honors in medicine, the Albert Lasker Awards of the American Public Health Association were instituted ten years ago not only to honor the recipients and dramatize their accomplishments but also to arouse increased public and professional interest in medical research and public health administration.

The achievements of the scientists and administrators thus honored are of themselves a ten-year chronicle of evidence that medical research saves both lives and money.

Among the most dramatic of these achievements was the incredibly complex research of Dr. John F. Enders of Harvard University, Lasker Award winner, and many other scientists who contributed the fundamental knowledge required for the development of the vaccine against poliomyelitis. One of a number of related scientific achievement in polio research, Dr. Enders' investigations resulted in ability to grow virus in huge quantities on a variety of nonnervous tissues. He and eight other Lasker Award winners have also received Nobel Prizes.

Of equal importance are the gains made in the control of tuberculosis since 1945 when another Lasker Award winner, Dr. Selman Waksman, discoverd the powerful new antibotic, streptomycin. This alone would have marked this decade as one of achievement toward the eventual victory against tuberculosis. A few years later, however, two groups of investigators working independently with two large pharmaceutical manufacturers added another new, powerful weapon against tuberculosis, isonicotinic acid hydrazide, known now as isoniazid or INH.

Those investigators, Drs. Walsh Mc Dermott and Carl Munschenheim, New York Hospital-Cornell Medical Center, New York; Drs Edward H. Robitzek and Irving J. Selikoff, Seaview Hospital, New York, and the Hoffman-La Roche Research Laboratories, Nutley, New Jersey, and the Squibb Institute for Medical Research, New Brunswick, New Jersey, were named group winners of an Albert Lasker Award October 31, 1955.

The list of other reseach gains that have been marked by the awarding of the gold statuettes of the Winged Victory of Samothrace, symbolizing victory over death and disease, includes recognition of such notable achievements as those of Dr. George Papanicolaou, who developed the smear test for cancer that bears his name; Dr. John Mahoney, who esta-

blished the value of penicillin in the treatment of syphilis; Dr. Conrad A. Elvehjem, who isolated the anti-pellegra vitamin, and Drs. Edward C. Kendall and Philip S. Hench, whose endocrine studies led to the ultimate discovery of cortisone and opened new approaches in the attack on arthritis.

Gains have not been limited to the discovery of new knowledge. They also have been made in the more widespread application and utilization of new scientific knowledge. The work of Lashker Award winners Drs. Frederick S. May and H. Trendley Dean, whose combined efforts led to the widespread fluoridation of water resulting in reduction of dental caries, illustrate these achivements. Recognition through Lasker Awards has also gone to such groups as the Health Insurance Plan for Greater New York, Alcoholics Anonymous, and the British Ministries of Food and Heath.

Related to these significant achievements of the past decade has been growing recognition of the value of medical research. During these ten years medical research supported by philanthropy has grown from $15,000,000 in 1945 to $25,000,000 in 1954. But the support of medical research by the U. S. Government which was negligible before World War II ($3,000,000 in 1941), has grown from $15,000,000 in 1945 to $119,000,000 in 1954.

In that year, for example, the Department of Health, Education and Welfare asked for $17,000,000 for research in disease of the heart and circulation. The U. S. Congress however, increased this amount by adding another $1,500,000 for heart research in the $91,674.000 appropriated for the research programs of the National Institutes of Health.

The complexities of medical research are such that it is impossible to isolate a single individual as the sole contributor to a significant medical discovery. Similarly no one individual or organization can claim the major credit for the increased professional and public interest in medical research. It is not pure coincident, however, that this development has paralleled the annual Albert Lasker Awards. The Albert and Mary Lasker Foundation and the American Public Health Association, by the creation of these awards ten years ago, have played a key role in the increased recognition that medical research saves lives and money.

This article appeared in the November 6, 1955, issue of *The New York Times*, one of the leading newspapers in the United States. The author, associate editor of that newspaper, is also director of the Institute of Rehabilitation and Physical Medicine of the New York University-Bellevue Medical Center and a consultant in rehabilitation to the United Nations. The article has been copyright cleared for distribution, translation and republication by USIS and the foreign press provided credit is given to the author and *The New York Times*.

A U. S. I. A. Magazine Reprint.

ASSOCIATION NEWS

CHETTINAD BRANCH

The monthly meeting of the Chettinad branch of I.M.A. was held on 18th Feb. '56 at the Sweedish Mission Hospital at 5-30 P. M. Dr. Miss H. Eriksson presided.

Dr. Israel presented two cases — 1. Operated case of Ankylosis Jaw and 2. Chronic parotitis - Clinical and sialographic findings. Then Dr. Wallden demonstrated a case of cerebral palsy and spoke briefly about the various types of cerebral palsy. Then Miss S. Person spoke about the education and occupational therapy that could be carried out in cases of cerebral palsy. Then Dr. D. S. Manuel read a paper on 'Extra Intestinal amoebiasis'. Dr. S. G. Sundaram gave the case record of a case of Pulmonary amoebiasis.

* * *

MADURAI BRANCH

The election of office-bearers for the year 1956 was conducted on 29-2-56.

Dr. Major. G. A. Naidu —*President*

Dr. K. A. Kalyanam—*Vice-President*

Dr. M. Venkatachalam Chetty, —*Treasurer*

Dr. K. A. Ramalingam —*Secretary*

Dr. Abdul Sattar
Dr. T. S. Renga Iyengar
Dr. A. K. Rajagopalan
—*Central Council Members*

1. Dr. Abdul Sattar
2. Dr. K. Balakrishnan
3. Dr. G. A. Naidu
4. Dr. P. Krishnan Menon
5. Dr. S. Natarajan
6. Dr. A. K. Rajagopalan
7. Dr. S. Swaminathan
8. Dr. S. Subbunarayanan

—*Madras State Council Members*

* * *

NILGIRIS BRANCH

The monthly meeting of the association was held at Pasteur Institute, Coonoor, on 24th March 1956 at 3 P.M. when Dr. L. Hiranandani, F.R.C.S., D.L.O., E.N.T. Surgeon, Bombay Hospital, Bombay addressed the meeting on 'OTITIS MEDIA AND ITS COMPLICATIONS'.

* * *

RAMNAD BRANCH

The Twenty Fifth Annual Meeting of the Ramanathapuram Dist. Branch of Indian Medical Association was held in the Municipal Council Hall, Virudhunagar at 4 P. M. on 25th March 1956.

Dr. M. D. Ananthachari, M. D., Principal of Madura Medical College presided over the function.

The following Office Bearers were elected unanimously :—

Dr. R. Venkatachari —*President*

Dr. T. Muthusamy —*Vice-President*

Dr. Radha Krishnan —*Secretary & Treasurer*

Dr. Mary Varghese
Dr. Raju Iyer
—*Managing Committee members*

Dr Padmanabha Iyer
Dr. Meenakshisundaram
—*Provincial Council*

Dr. Jayabalraj —*Central Council*

Major G. A. Naidu gave an interesting lecture on "Virus Diseases of the Skin".

Dr. K. S. Krishnan, gave an interesting lecture on "Vaginal Discharge". He explained in great detail the causes and treatment of Vaginal Discharge.

There was a film demonstration on "Virus Research" by Lederle Laboratories.

With a vote of thanks, the meeting terminated at about 9-30 P.M. after a grand dinner arranged by Messrs. The South Indian Manufacturing Co.

* * *

SALEM BRANCH

At the Annual General Body meeting held on 31—3—56, the following office bearers have been duly elected.

Dr. P. S. Ramaswamy —*President*

Dr. S. Valeeswaran —*Vice President*

Dr. V. Raghavendra Rao,
—*Hony. Secretary*

Dr. S. Arthanarai—*Hony. Joint Secretary*

Dr. K. V. Dhanakoti Naidu,
Hony. Treasurer

Dr. U. B. Lakshmi
Dr. S. Kannan
Dr. S. Krishnamoorthy Rao
Dr. A. J. Arunagiri
Dr. T. Narayanaswamy
—*Executive Committee members*

Dr. K. R. Hariharan
Dr. S. R. Rajaram
—*Representatives to the Central Council*

Dr. S. Valeeswaran
Dr. K. Govindarajulu
Dr. T. Narayanaswamy
—*Representatives to the State Council*

Dr. M. Mahadevan
Dr. J. Sugavanam
—*Auditors.*

Dr. K. C. Nambiar, F.R.C.S. (Eng.) F.R.C.S., (Edin) addressed the members on "The role of the General Practitioner in the field of Surgery" and Dr. M. S. Mehkri, B.Sc., M.B.B.S., D.O.M.S. (Lond.) addressed on "The Eye in Vitamin Deficiencies".

* * *

TIRUCHY BRANCH

A meeting of the association was held on 25th February 1956 in the premises of the Medical Association Buildings, Salai Road, Woraiyur, Tiruchy. Dr. A Umapathy Mudaliar, M.B.B.S., M.F., took the chair. Dr. P. Vadamalayan, M.B.B.S., Madurai delivered a lecture on "Enlarged Prostate".

A meeting of the association was held on 24th March 1956 in the premises of the Rajaji Tuberculosis Sanatorium, Tiruchy. Dr. V. Enok, MBBS, LM, DGO, ZGO, took the chair. Dr. C. S. Sadasivam, MS, Superintendent, Govt. Tuberculosis Sanatorium, Tambaram addressed the members on "Management of Empyema."

* * *

CORRESPONDENCE

Dr. R. V. Rajam, M.S., F.R.C.P.,
Director, Institute of Venereology,
Govt. General Hospital, Madras.

Madras, 17—3—1956.

My dear Kalamegham,

Thanks for your letter. I am sure that the new clinical journal has shown improvement under your management. If you do not take it amiss I may suggest that the journal should publish more and more of case reports of special or rare interest in which the diagnostic difficulties and treatment problems are to be discussed. Such well written case reports will be more useful to the general practitioner than long articles which are merely reproduction from books and it is up to the practitioners of the whole of South to get into the habit of reporting interesting cases. Some time ago I sent round a request to the Presidents of the several District Branches of the Indian Medical Association in our state to help me to collect some data with regard to the serious allergic reactions to penicillin but I am sorry to find that nobody has taken any notice of it. I am enclosing herein the circular and the proforma and if you will be good enough to get them published in the new clinical journal with a request to all the practitioners to report their experiences of penicillin reactions in the proforma, you will be doing a good service. (Published in the March 56 issue of the Madras Clinical Journal.) You might even request that the data may be sent to you and that could be published in your journal as and when you get them. This suggestion will be my contribution to your journal for the present.

With kind regards,

Yours sincerely,
R. V. RAJAM.

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Managing Editor.

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Managing Editor.

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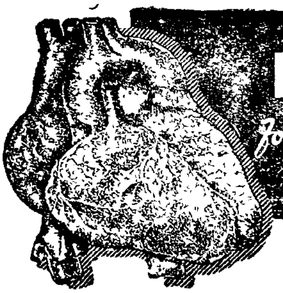

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ANNOUNCEMENTS

Sub: Medical Bulletin - availability of copies.

150 copies of No. 5, 140 copies of No. 4 and 15 copies of No. 3 are available for distribution to the members of the I.M.A., at a cost of 6 annas per copy. The Government have recently decided to make available copies of the Bulletin to all Regd. Medical Practitioners in the State through the agency of the Indian Medical Association. The Hony. Secretary hopes that all Regd. Medical Practitioners in the State would take advantage of this concession made by the Government and obtain the Bulletin from the undersigned. It would be helpful if intending subscribers to the Medical Bulletin register their names with the Hony. Secretary, Madras State Branch, I·M A., before hand so that the Hony. Secretary may be in a position to indent for sufficient number of copies from the office of the director of Medical Services. Madras. The Hony. Secretary regrets that copies of Nos. 1 and 2 of the Bulletin are not available, they having not been supplied by the Director of Medical Services on the ground that they are not priced.

R. Sankaran, L. M. P.

Hony. Secretary, Madras State Branch,

Indian Medical Association.

REGISTERED No. M. 4839 *April-1956*

CIRCULAR

Sub: Medical Certificates of sickness granted by Regd. Medical Practitioners - need to take the signatures or thump impressions of the patients to whom the certificate is given - decision of the Working Committee of I.M.A. Delhi.

The Registrar, West Bengal Medical Council, Calcutta, addressed the Central Office of the Indian Medical Association, Delhi, that certain medical certificates of sickness granted by Regd. Medical Practitioners have been misused by impersonation etc., leading to complaints from employers, that the concerned Medical Practitioners were unable to identify the person to whom certificates were granted as they are not expected to know the real names of all the persons who come to them for treatment and also due to lapse of time, and that therefore a provision made in the All India Code of Medical Ethics requiring registered practitioner to note down the address and two identification marks of the patients and have their signatures or thumb impressions in the medical certificates issued by them will prevent the misuse. The Working Committee of the I.M.A., Central Office, after a thorough consideration and discussion of the matter, decided that for proper identification either the signatures of the person of the thumb impression should be enough in the case of a medical certificate. Though the practice of taking the signatures of the patients before granting the medical certificates is greatly in vogue in this State, all Regd. Medical Practitioners are nevertheless requested to make it a rule to take signatures of the persons to whom they grant medical certificates of sickness or fitness both in order to prevent the misuse of the certificates as well as to enable them to identify the persons on a future occasions, if need be.

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